BEFORE THE
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
STATE OF CALIFORNIA

In the Matter of the Petition for Early Termination of Probation by: PO LONG LEW D.O., Osteopathic Physician and Surgeon's License No. 20A 5380 Petitioner.	Case No. 00-2006-001753 OAH No. 2011120482

DECISION

A quorum of the Osteopathic Medical Board of California (Board), comprised of Geraldine O'Shea, D.O.; President; Joseph Provenzano, D.O.; Paul Wakim, D.O.; Susan Melvin, D.O.; Veronica Vuksich, D.O.; Alan Howard, Scott J. Harris, Esq. and Keith Higginbotham, Esq. heard this matter in Sacramento, California, on January 5, 2012.

Administrative Law Judge Ann Elizabeth Sarli, Office of Administrative Hearings, State of California, presided.

Jessica Amgwerd, Deputy Attorney General, represented the People of the State of California pursuant to Government Code section 11522.

Po Long Lew D.O. (petitioner) was present and represented himself.

The matter was submitted on January 5, 2012.

FACTUAL FINDINGS

1. On July 1, 1987, the Board issued Osteopathic Physician and Surgeon's License No. 20A 5380 to petitioner.

2. On June 24, 2008, the Executive Director of the Board issued an Accusation against petitioner in Case No. 00-2006-001753,[1] which alleged that respondent was subject

[1] OAH No. L2008080570

to disciplinary action under Business and Professions Code[2] section 3600, for multiple violations of the Code in his care and treatment of 14 patients in 2004 and 2005. The Accusation alleged multiple violations of section 2234, subdivision (b) (gross negligence); section 2234, subdivision (c) (repeated negligent acts); section 2234, subdivision (d) (incompetence); section 725 (repeated acts of clearly excessive treatment); section 2260 (failure to maintain adequate and accurate medical records); and section 2285 (practicing under fictitious name without permit).

3. The Accusation also alleged as a disciplinary consideration the fact that the Board had revoked petitioner's license on December 19, 2001. The revocation had been stayed and petitioner had been placed on probation for five years, subject to terms and conditions, among others, that petitioner complete the Physician Assessment and Clinical Education Program, and complete approved medical record-keeping and professional ethics courses. This probationary term ended on December 19, 2006.

4. On March 29, 2010, petitioner entered into a Stipulated Settlement and Disciplinary Order wherein he agreed that complainant could establish a factual basis for the charges in the Accusation. He agreed that the charges in the Accusation constitute cause for imposing discipline upon his license and he gave up his right to contest those charges. Petitioner agreed to be bound by the imposition of discipline set forth in the Disciplinary Order. The Board adopted the Stipulated Settlement and Disciplinary Order on December 22, 2010, as its Decision and Order. The Decision and Order became effective on January 5, 2011.

5. The Decision and Order revoked petitioner's license, stayed the revocation and placed petitioner on probation for five years on terms and conditions. Petitioner's five-year probationary term ends in January 2016. The Decision and Order contain a provision that petitioner may apply for early termination of probation at the end of the first year of probation if he had successfully completed the Physician Assessment and Clinical Education (PACE) Physician Enhancement Program and paid to the Board the full amount of cost recovery.

6. On November 8, 2011,[3] petitioner signed a Petition for Termination of Probation with the Board, and filed it shortly thereafter. The petition requests that probation be terminated or, in the alternative, that petitioner's enrollment in the Physician Enhancement Program be terminated. Included in the petition is petitioner's statement, letters of support/reference, certificates of continuing medical education and quarterly probation and Physician Enhancement Program reports.

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[2] All statutory references are to the California Business and Professions Code, unless otherwise noted.

[3] Petitioner filed the petition after he had completed less than one year of probation. Nevertheless, the Board considered the petition.

Petitioner's Statement and Testimony

7. Petitioner's statement asserts that he has always provided the utmost medical care to all of his patients for over two decades. His patient are "very content" with his medical services and have "never had any issues or complaints about the medical care they received." He explained that he has complied with all of the terms and conditions of probation. He has been using an electronic medical record-keeping system called Patient Max since May 2008, to better improve and document his charting to avoid illegible handwriting. He has passed all Medi-Cal, Blue Cross HMO, CHD and other insurer audits with high scores. He asserts that according to the Physician Enhancement Program monitor, his progress notes and treatment plans of each patient had been above the standard. He explained that he enrolled in the Physician Enhancement Program in October 2009, more than a year before he started probation. He is still in the program, although he was "supposed be enrolled for only one year." He asserted that he has successfully and satisfactorily completed the requirements given by the program. He sends monthly charts which are verified and guided by Dr. Alison Ross from the program. Dr. Ross also comes to the office and reviews his systems. His reviews have been outstanding and he has no negative marks. He complained that he has to pay over $10,000 a year for the Physician Enhancement Program and this is putting a lot of strain on his finances.

8. Petitioner asserted that he is current with his continuing medical education hours and is "always looking out for more CME courses in diverse areas to be updated on a broad spectrum of top topics." He attended the 2011 Western States Osteopathic convention in Las Vegas April 6 through April 10, 2011. He attends this every year. He also recently attended a conference about aesthetic medicine, accredited by the American Academy of Family Physicians, in Las Vegas on August 6, 2011 on August 7, 2011. He has been reading and answering several questions in the American Family Physician magazines and he co-wrote and published an article relating to dietary patterns and nutrition intake. He asserted that he has spent time performing voluntary medical services to serve the poor and minorities in his community.

9. Petitioner asserted he is in good standing with all affiliated hospitals for over 20 years with no lawsuits. He noted that he is as "suffering emotionally and financially because Blue Cross, CIGNA and other major insurance companies repeatedly contact [him] about his probation." He has to "interview and explain every time." "The notice on the website causes [him] a lot of strain and stress."

10. Petitioner testified in accordance with his written statement. He explained that his discipline resulted from "sloppy handwriting and sometimes ordering unnecessary tests." He acknowledged that the Accusation alleged that he ordered bone scans on multiple patients, including young men and patients who had no risk factors for osteoporosis. Petitioner explained that that he ordered tests appropriate to the patient, but Medi-Cal cited him for doing this. He has already "changed this pattern" and sends all diagnostic tests out of the office. He has removed the DXA scanner from his office. Now, he documents the reasons for all tests ordered. Petitioner also submitted copies of his charting records to

demonstrate that his charting is now appropriate. He explained that the Physician Enhancement Program physician reviews his charts and comes to his office for a day and watches him work with patients. Petitioner also acknowledged that the allegations in the Accusation pertained to patients he was treating while he was on probation due to his first discipline.

11. Petitioner's statement and testimony were remarkable for his lack of acknowledgment as to the nature and extent of the conduct that led to his most recent discipline. Petitioner repeatedly characterized his discipline as arising from "sloppy handwriting and record keeping." Because he has corrected his charting errors and been reviewed under Physician Enhancement Program for over a year, he feels he has sufficiently established his rehabilitation.

12. However, the clinical conduct that led to petitioner's most recent discipline was a repeat of the conduct alleged in his 2001 discipline, and was far more egregious than "sloppy handwriting." The Accusation shows petitioner habitually had incomplete, illegible, clearly erroneous and contradictory charting and treatment plans which did not coordinate with the complaints, evaluations or diagnoses. In addition, he had performed incompetently and in extreme departure from the standard of care on multiple occasions.

13. A sampling of the 14 patients identified in the Accusation disclosed the following standard of care issues:

(1) Petitioner ordered bone density scanning for 31-year-old male with symptoms of a cold and a one week history of low back pain after falling at home. He prescribed an antipsychotic medication, Haldol, without a corresponding diagnosis and prescribed two different acetaminophen containing medications, together totaling a potentially toxic dose of acetaminophen;

(2) Petitioner ordered a bone scan test for a 41-year-old obese male who presented with complaints of total body pain and three days of sinus congestion with a history of diabetes and congestive heart failure;

(3) Petitioner prescribed a medication for GERD (Previcid) for a patient at the same time he prescribed medications known to worsen this condition (Celebrex, Fosamax). This 52-year-old female patient had a history of high cholesterol and smoking and presented with chest pain for three days associated with dizziness, shortness of breath and was not relieved by nitroglycerin. Her blood pressure was 144/ 96 and her pulse recorded at 72. An EKG was distinctly abnormal with an elevated heart rate of 101 and changes suggested of lateral eschemia. Petitioner did not order blood tests, did not refer the patient to a cardiologist and did not direct her to go to the emergency room. His treatment plan was a low sodium diet;

(4) Petitioner did not evaluate a 47-year-old male patient for STDs, despite urinary complaints, did not treat for hypertension despite elevated blood pressure on two office visits and diagnosed the patient with hyperlipidemia on the basis of a single elevated triglyceride on a non-fasting specimen,

(5) A 46-year-old female patient saw petitioner on 13 occasions, initially complaining of painful urination and requesting birth-control pills. Petitioner failed to perform a pelvic examination and a Pap smear during the first 18 months, ordered excessive blood tests, ordered an unnecessary pregnancy test, compelled the patient to return every three months for contraceptive refills and billed for excessive counseling. He ordered sex hormone assays in the patient who was using hormonal contraceptives and failed to obtain a urine culture. When a Pap smear returned as inadequate cells for analysis, respondent failed to repeat the pelvic or mentioned the need to schedule a repeat Pap smear.

(6) Petitioner ordered a bone density scan for a 35-year-old male with no risk factors for osteoporosis. The patient complained of mental health problems and insomnia. Petitioner prescribed Thorazine and the highest dosage of Seroquil without first increasing the dosage of Rispirdol or consultting with a psychiatrist. Petitioner ordered a blood pressure medication although the patient's blood pressure was within normal limits.

(7) Petitioner treated a patient with a vaginal yeast infection with an intra-vaginal antibiotic rather than an antifungal medication.

(8) Petitioner ordered x-rays, a carotid ultrasound, a venous Doppler, an echocardiogram and a DXA scan for a 54-year-old male with long-standing back pain. Petitioner rendered a diagnosis of osteoporosis and prescribed calcium supplements for the patient despite the patient's normal T-score. He diagnosed carotid stenosis and heart failure without supportable physical findings.

(9) Petitioner erroneously diagnosed a 53-year-old female with osteoporosis, prescribed Vicodin to the patient when she reported an allergy to codeine, prescribed Fosomax to the patient after a normal DXA scan and no fracture history and prescribed Zoloft when there was no evidence the patient was suffering from clinical depression.

Petitioner's Supporting Documentation

14. Petitioner submitted in evidence one page of a March 30, 2010, letter to Nathaniel Floyd, case manager Physician Enhancement Program, UCSD PACE Program. The author is unknown but presumably the author is the Physician Enhancement Program monitor who was assigned to review petitioner's progress. The letter states in pertinent part

that it is a quarterly report for November and December of 2009[4] and the author had reviewed petitioner's progress notes during that period. The letter notes that for the month of November the author reviewed seven progress notes. Two of these progress notes were below standard, three met standard and two set standards. The author discusses the two notes which were below standard. However, as only page 1 of the letter is provided, there are three paragraphs of information regarding the first note only. In pertinent part, the author states:

> The first note was of an encounter with TU, a 27yo female who presented for lab results and dizziness for two months. The history and physical was adequate, although some of the documentation of the labs were unclear. For example "Hepatitis A (POS)" was documented but did not specify whether this was IgM, indicating acute disease, or IgG indicating immunity. Also CBC (Complete Blood Count) was partially documented without the MCV (mean corupuscular volume) which would be necessary to make the diagnosis listed in the Assessment portion of the note. Also an LDL of 103 was documented as (H) which I assume to mean high, although a normal LDL for women at low risk is [less than] 160.
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> The Assessment listed "Pernicious Anemia" as the diagnosis, however this is another name for macrocytic anemia caused by vitamin B 12 deficiency. There was no evidence from the labs that there was a macrocytosis (high MCV) or that vitamin B12 is checked. If the diagnosis was made in error and was meant to state an anemia of unknown etiology, further testing should have been done to determine the etiology of her anemia.
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> In the plan, the patient was prescribed "FESO4 5 gram 1 tab bid". Not only was this not indicated by a diagnosis of "Pernicious Anemia" and the lack of iron studies, but this is an incredibly high dose. The usual dose for iron deficiency anemia is 325 mg of ferrous sulfate three times daily. Also a low-calorie, low-fat diet was recommended, but not indicated for this woman with a BMI of 20 and normal cholesterol.

15. Petitioner submitted a June 16, 2001, letter from Alison Ross M.D., Physician Enhancement Program monitor, who reviewed his chart notes for the months of January through May 2011. During these five months, she found all of his notes set standards. She wrote: "There were no deficiencies and all the documentation was clear and thorough. His medical management is always appropriate and he documented follow-up plans with education of the patient on his or her disease. He incorporated preventative medicine, vaccinations and healthy lifestyle modifications into each encounter" Dr. Ross "congratulated" petitioner "on a job well done." In general, she found petitioner's documentation had been outstanding and there were very few if any recommendations she

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[4] Petitioner began participating in the Physician Enhancement Program before the Board's Decision and Order was final.

could offer for improvement. She found he was a conscientious physician who provided a valuable service to his community.

16. Dr. Ross also reviewed petitioner's progress notes for the months of June through September 2011. All of his notes set standards, except one which met standards. Dr. Ross wrote that the notes were clear, organized, and thoroughly and clearly explain the purpose of the encounter, the assessment and plan.

17. Petitioner submitted in evidence letters from three references. Board personnel verified with the authors that they wrote these letters. Irvin Benowitz, D.O., Lakeside Medical Group, wrote on October 11, 2011, that he has known petitioner over 20 years and has always known him to be an organized, responsible and easy-going individual. "His skills and experience in osteopathic medicine and family practice make him an excellent and competent physician." He recommended termination of petitioner's probation. Philip Lee, D.O., wrote on October 4, 2011, that "petitioner's performance working in the medical field is a valuable addition to any community, hospital and patient." He has known petitioner for 20 years in the capacity of a family physician working in the Burbank community. Dr. Lee wrote that petitioner had worked with him at various hospitals and he was familiar with how petitioner performed in any situation with the patient. Petitioner "treats patients exceptionally well and has well written reports and documentation." Dr. Michael Tan, D.O., wrote on October 15, 2011, that he has known petitioner for many years. They both staffed at Garfield Medical Center, San Diego Valley Medical Center and Monterey Park Hospital. Dr. Tan has provided neurology consultation for petitioner's patients. Dr. Tan wrote that petitioner is a competent physician and he would make a great asset to any organization. Dr. Tan urged that petitioner's probation be terminated

18. Petitioner also submitted letters from his patients and letters confirming that petitioner had privileges at Alhambra Hospital Medical Center, Monterey Park Hospital and Garfield Medical Center. He submitted documentation from the Quality Improvement Department at Healthcare Partners Medical Group dated September 9, 2010, confirming he had passed a compliance review with a score of 98%. He submitted a completion of audit form dated, August 21, 2009, from Anthem Blue Cross confirming he had met all the required standards. He also submitted a certificate acknowledging that he had successfully completed the Department of Health Services, Medi-Cal Managed-Care Division, site review in June 2009, and had been re-credentialed by Pacific IPA credentialing committee and Advantage Care in 2009.

19. Petitioner submitted evidence that he has completed 147.50 credits in continuing medical education n 2010 and 2011. The courses related to osteopathic medicine and aesthetic medicine. Petitioner also submitted an article he wrote in December 2010 regarding a comparison of dietary patterns and nutrient intakes.

He submitted a certificate of appreciation dated March 26, 2011, for his presentation, "Managing Physical Health," at the community resources fair for older adults at the Asian Pacific Family Center.

He submitted a letter from George Poon, Director of Chinatown Senior Citizen Service Center, dated October 25, 2011, which states that petitioner has been providing free community health services, including blood pressure screening, health and nutritional counseling and education. Petitioner submitted a December 15, 2011, letter from the Chief Executive Officer of Allied Physicians of California, advising that petitioner had been elected as a member of the Board of Directors for the year 2012.

Discussion

20. The evidence is persuasive that petitioner has been meeting the terms and conditions of probation during the 10 months before he filed his application for early termination. However, mere compliance with probation is not cause for early termination of probation, nor is it cause to discontinue a condition of probation. Petitioner has been placed on probation twice, for both charting errors and extreme departures from the standard of care in his care and treatment of multiple patients. Pursuant to the terms and conditions of petitioner's probation, the Physician Enhancement Program is the only tool available to the Board to monitor petitioner's level of care. He was performing below the standard of care in November and December of 2009 (Finding 14). His performance has improved considerably pursuant to the more recent evaluations. Nevertheless, petitioner must demonstrate sustained performance within the standard of care over a prolonged period of time in order to assure the Board that he is safe to practice unmonitored. Additionally, the terms and conditions of petitioner's probation do not provide that petitioner remain in the Physician Enhancement Program for only a year. Rather, the condition provides that petitioner shall enroll in the program and shall complete the program within a timely manner as determined by the PACE program. Petitioner did not submit documentation that PACE has determined that he has successfully completed the Physician Enhancement Program.

21. It is also a concern of the Board that petitioner has not accepted responsibility for the deficiencies which led to his disciplines. He continues to attribute the prior disciplines to "sloppy handwriting," and believes he has solved the problem by using a computer program to assist in charting. Indeed, he seemed perplexed that the Board continues to have concerns, now that he uses the charting program and no longer refers patients for in-house DXA scans. The multiple instances of sub-standard care alleged in the Accusation occurred during petitioner's first probationary term, while petitioner was in the PACE program or shortly after he completed the program. Accordingly, it is even more critical that petitioner demonstrate sustained performance within the standard of care over a prolonged period of time in order to assure the Board that he is safe to practice.

LEGAL CONCLUSIONS

1. California Code of Regulations, title 16, section 1657 sets forth the criteria for the Board to consider when reviewing a petition for early termination of probation or modification of probation:

> When considering a petition for reinstatement or a petition for modification of penalty, the Board, in evaluating the rehabilitation of the applicant and his present eligibility for a certificate or permit, may consider all activities of the petitioner since the disciplinary action was taken and shall also consider the following criteria:
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> (1) The nature and severity of the act(s) ... for which the petitioner was disciplined;
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> (2) Evidence of any act(s) ... committed subsequent to act(s) ... for which the petitioner was disciplined which also could be considered as grounds for denial under Code Section 480.
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> (3) The time that has elapsed since commission of the act(s) ... referred to in subdivision (1) or (2) above.
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> (4) The extent to which the petitioner has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed.
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> (5) Petitioner's activity during the time the certificate was in good standing.
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> (6) Evidence, if any, of the rehabilitation submitted by the petitioner.
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> (7) Petitioner's professional ability and general reputation for truth.

2. The quality of care issues for which petitioner was disciplined were serious and pervasive. His two disciplinary actions cover at least a five year period of practice and pertain to multiple patients. His second probationary term was imposed for essentially the same quality of care issues as the first probationary term. It would not be in the public interest to terminate or modify petitioner's probation at this time.

3. Petitioner bears the burden of establishing that it is appropriate to terminate probation early. He also bears the burden of establishing that it is appropriate to end his

participation in the Physicians Enhancement Program. As set forth in the Findings, petitioner has not met these burdens.

ORDER

Po-Long Lew's Petition for Early Termination of Probation and Termination of the Professional Enhancement Program is DENIED.

DATED: March 20, 2012.

Geraldine O'Shea, D.O.
President
Osteopathic Medical Board of California